How We Get to Affordable, Quality Healthcare

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NCQA
Measuring quality.
Improving health care.

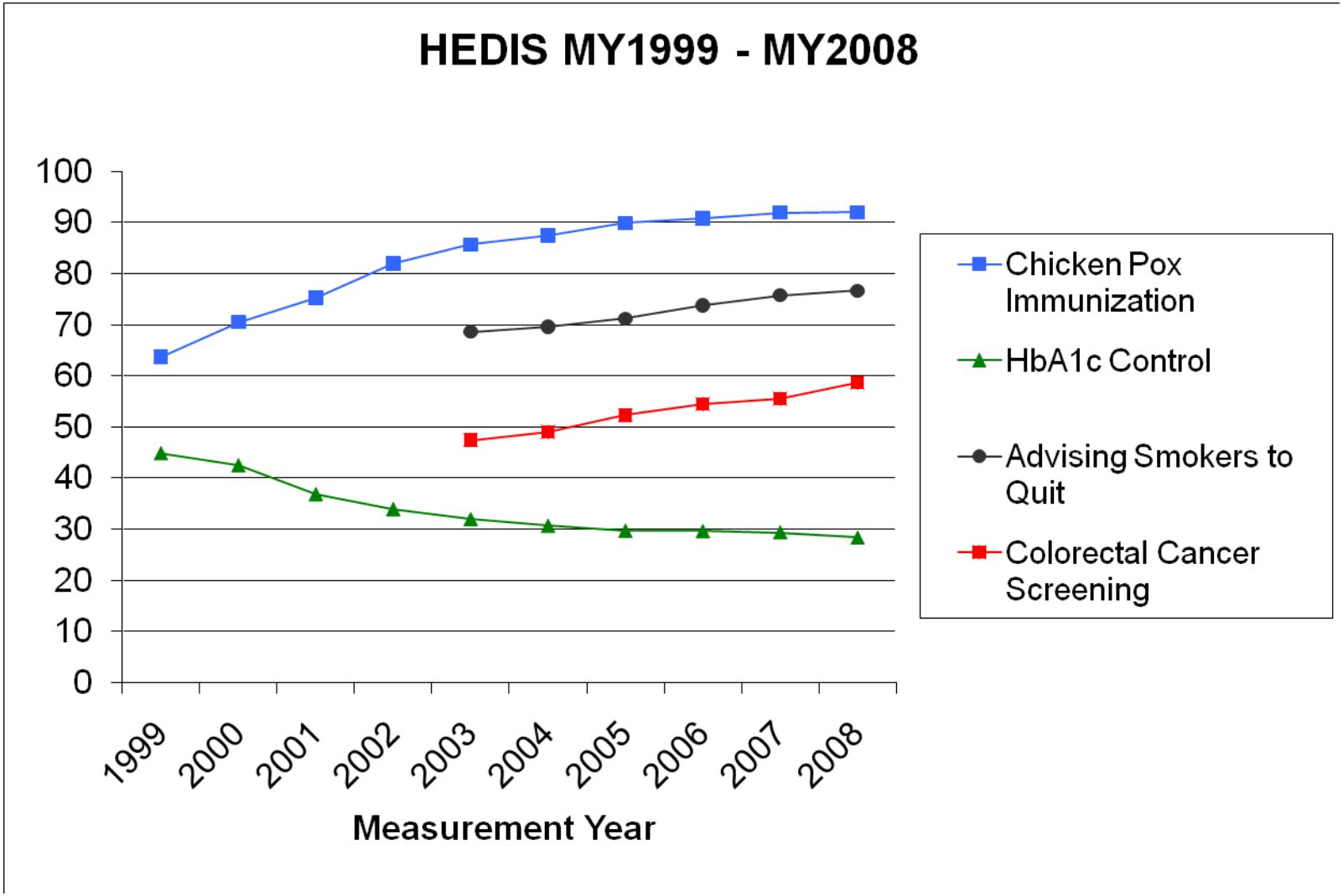
ABOUT TODAY'S PRESENTATION

- About NCQA
- Getting to affordable health care
- High prices
- High volume
  - Relative resource use
  - New models of care: medical homes and accountable care organizations
- The role of patients and rethinking the Cadillac plan

NCQA: A BRIEF INTRODUCTION

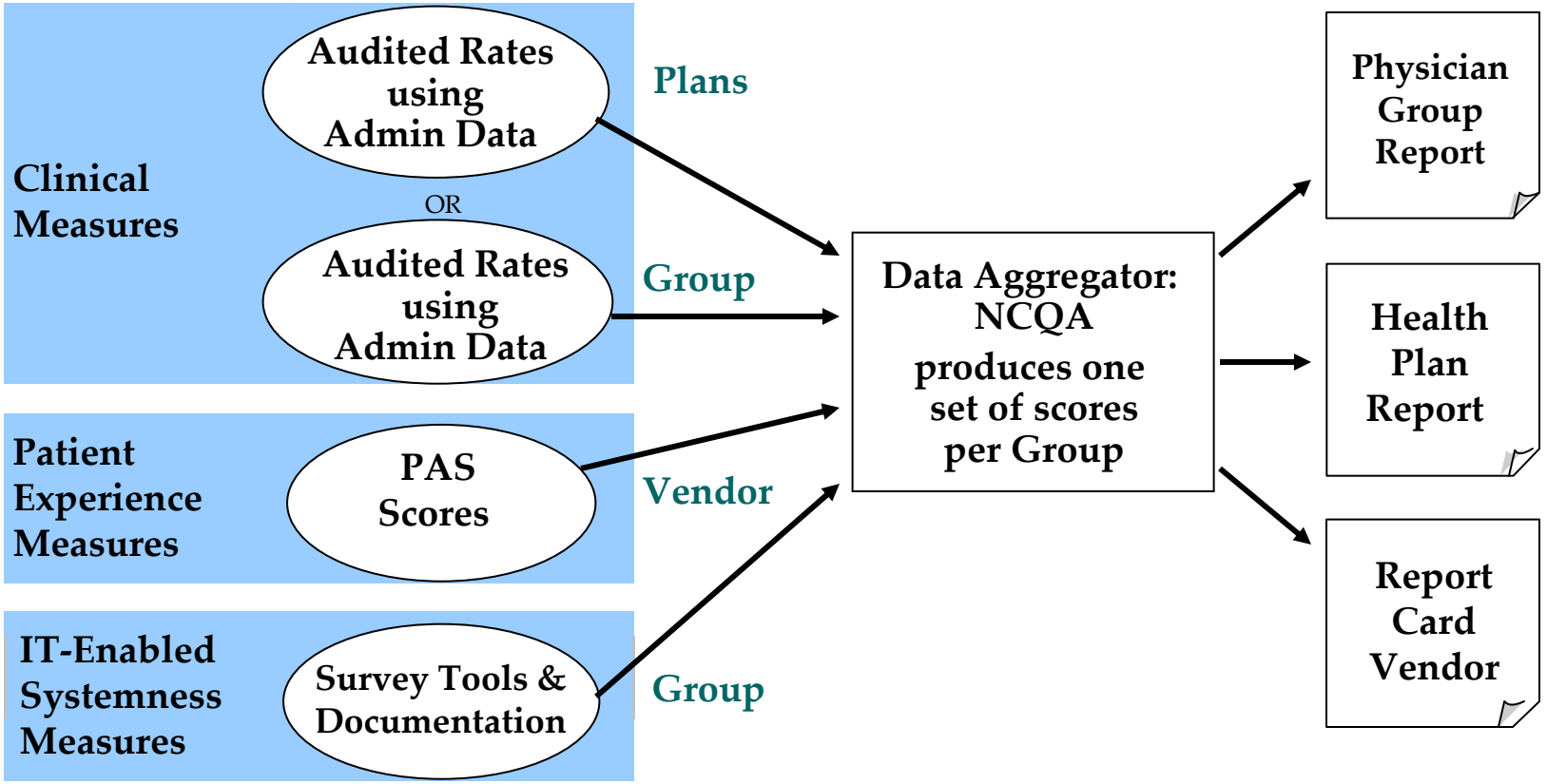
- **Private, independent non-profit health care quality oversight organization founded in 1990**
- **Mission: To improve the quality of health care**
- **Committed to measurement, transparency and accountability**
- **Unites diverse groups around common goal: improving health care quality**

SELECT IMPROVEMENTS: 1999 – 2008



***Lower is Better for HbA1c measure**

NCQA'S ROLE IN PAY FOR PERFORMANCE



GETTING TO AFFORDABLE HEALTH CARE

Multiple causes of high cost, cost growth in U.S. health care system

- **High prices**
- **Growth in volume, particularly specialized and discretionary services**
  - **Overuse**
  - **Inefficiency and waste (e.g. paper records)**
- **Individuals' overconsumption**
  - **behaviors that lead to poor health**
  - **Sense that more is better**

Solutions

- **Many experts have discussed:**
  - **Need for payment reforms to change incentives,**
  - **importance of evidence,**
  - **potential of HIT,**
  - **giving more value to primary care (medical education, higher payment, delegation)**
- **Focus today on measures, delivery system standards, vision for excellent health plan**

HIGH PRICES

Massachusetts' Attorney General finds high prices driving high cost

Investigation of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 118G, § 6½(b)

Preliminary Report

January 29, 2010

Office of Attorney General Martha Coakley
One Ashburton Place • Boston, MA 02108

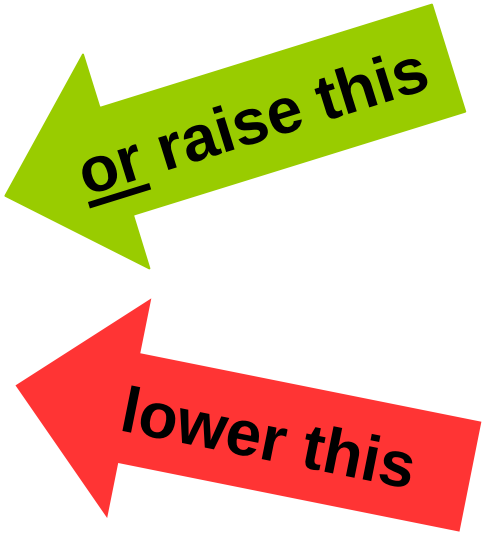
HIGH VOLUME

Strategies to address high volume

- **Measures of resource use to capture efficiency**
- **Changing models of payment and care delivery**
  - **Patient-centered medical home**
  - **Accountable care organizations**

WHAT IS EFFICIENCY?

$$\text{Efficiency} = \frac{\text{Quality}}{\text{Cost}}$$



To improve efficiency…

- **Cheaper care isn't necessarily more efficient!**

RELATIVE RESOURCE USE

WHAT ARE RRUs?

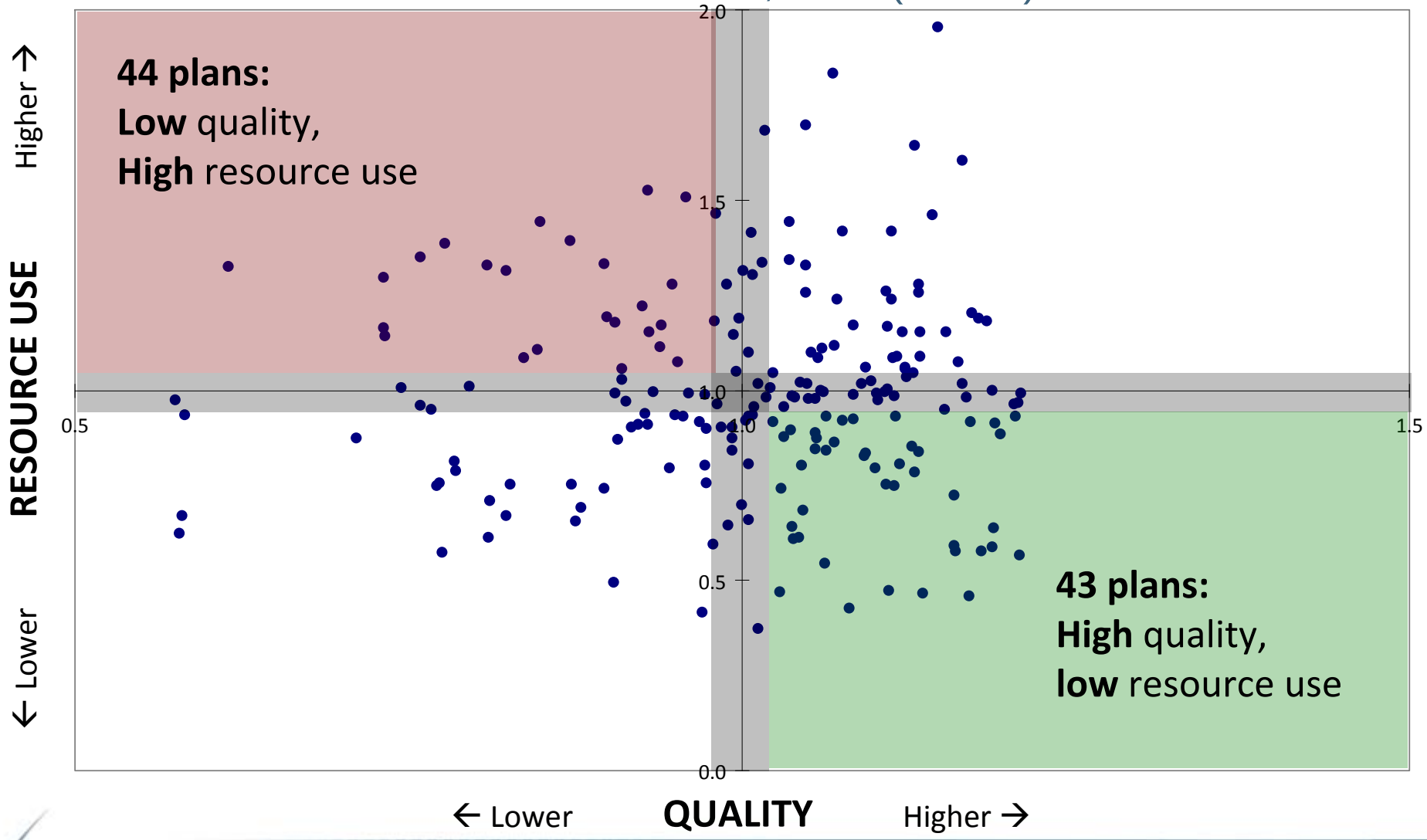
- **RRU measures describe medical care utilization for members with:**
  - Diabetes
  - Asthma
  - Acute Low Back Pain
  - CVD
  - COPD
  - Hypertension
- **Account for >60% of total medical spend**
- **Categories of resource use include:**
  - Inpatient facility use
  - Inpatient and outpatient procedures and surgeries
  - Inpatient and outpatient evaluation & management
  - Outpatient Pharmacy use
- **RRU measures compare plan observed use of services to 'expected' use**

THE PRINCIPLES BEHIND RRUs

- **Link measures of resource use to quality**
- **Build on existing HEDIS quality measures**
- **Benchmark resource use, not unit price**
- **Methods must be fair and transparent**
- **Begin with what can be measured today, improve methods and expand scope over time**

Relative Resource Use:

Total Medical Costs (exc. Rx) For Patients with Diabetes
Commercial Plans, 2008 (n=206)



WHAT LINES CAN WE DRAW CONNECTING COST AND QUALITY?

- **None.**

IT'S A MESS...

- Results reflect highly fragmented payment and delivery systems
- But "measuring the mess" is a start
- Ultimately, to be applied at two levels
  - Care systems
  - Physician practices
- Highlights need for comprehensive payment, delivery system reform

…BUT THERE'S GOOD NEWS

- **Results show how cost is a lousy proxy for quality**
  - **Message to purchasers: You *can* get more for less!**
- **Can find "islands of accountability" in certain aspects of the system and build outward**
  - **BCBS-NJ measuring radiation exposure from imaging, working to minimize exposure among elderly, children**
- **Delivery system reform – with strong accountability provisions built in – will clarify the picture**
  - **We need providers to have their shoulder against the wheel to bring meaningful change**
  - **ACOs are a critical piece of delivery system reform; Medical Home a good platform for ACOs**

WHAT'S NEXT FOR RRUs?

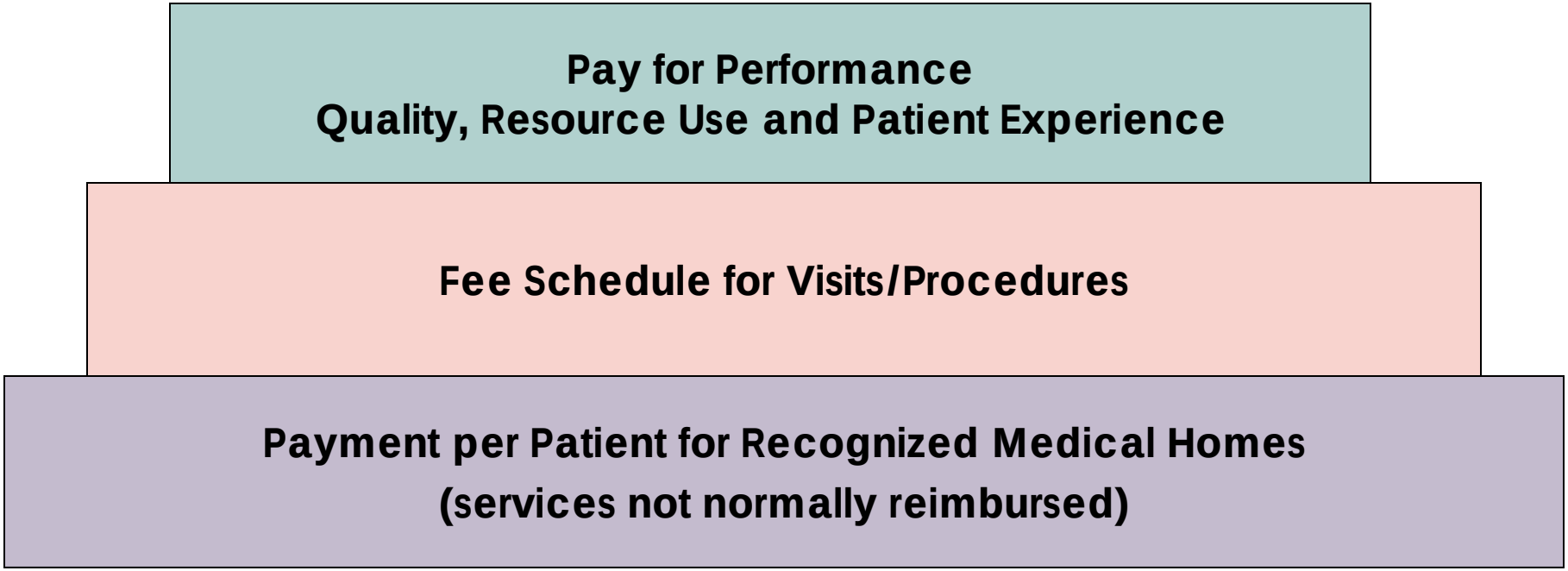
- **Relative Resource Use (RRU) Measures to move to public reporting**
  - **Five RRUs set for public reporting in 2010: Diabetes, Asthma, COPD, CVD, Hypertension**
- **Purchasers can use plan-specific RRU data in contracting decisions**
- **Building new, more robust reporting approaches to facilitate comparisons**

NEW MODELS OF CARE: PATIENT CENTERED MEDICAL HOMES AND ACCOUNTABLE CARE ORGANIZATIONS

Goals for Patient Centered Medical Home

- **Evaluate systematic approach to delivering preventive and chronic care (Wagner Chronic Care Model)**
- **Build on IOM's recommendation to shift from "blaming" individual clinicians to improving systems**
- **Create measures that are actionable for physician practices**
- **Validate measures by relating them to clinical performance and patient experience results**

Linkage of PCMH to Reimbursement: One Model



Accountable care organizations

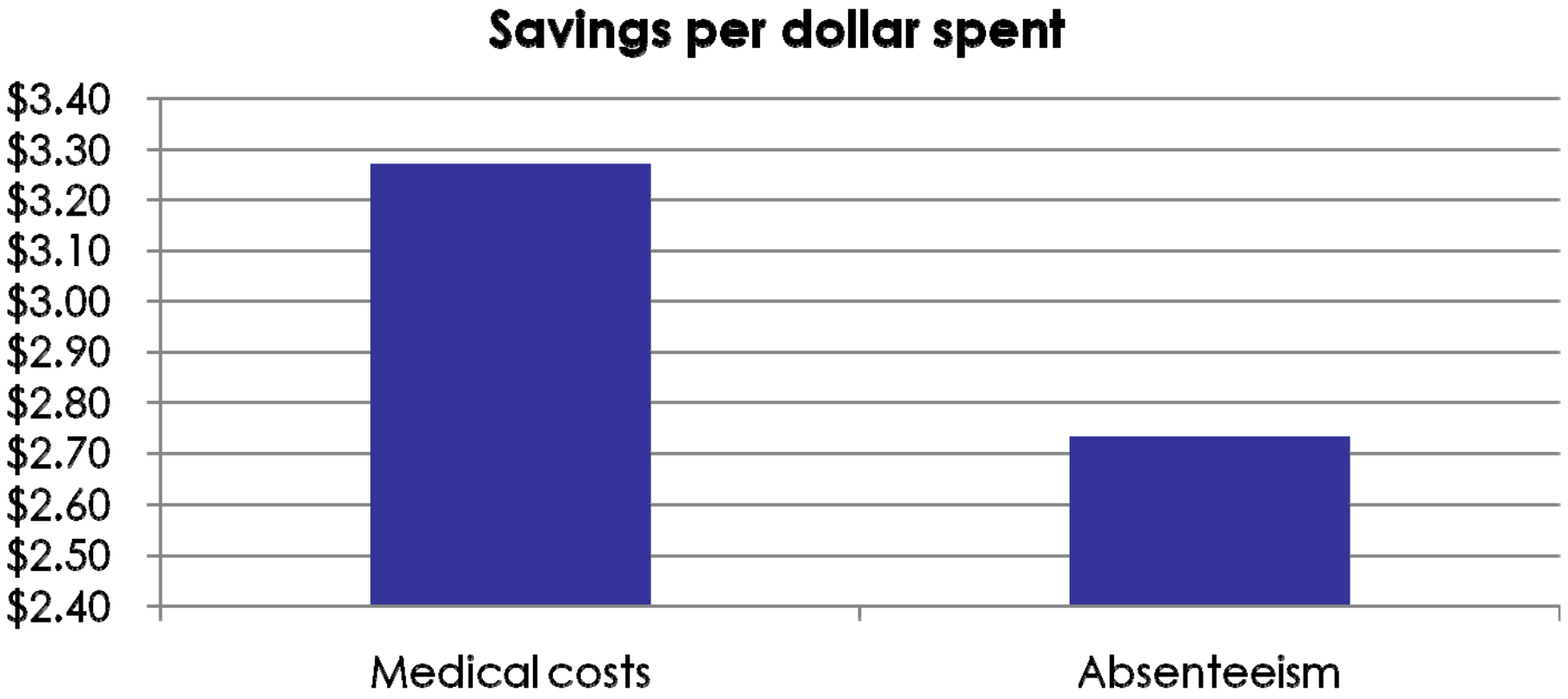
- **Vision: networks of providers rewarded for high quality and lower volume**
- **Goes beyond medical home to include specialists, potentially hospitals**
- **NCQA task force is developing standards to recognize and evaluate ACOs**
- **Standards need to reflect diversity of delivery systems**
- **Qualifying vs. monitoring criteria**

THE ROLE OF PATIENTS AND RETHINKING THE CADILLAC PLAN

What is patient engagement?

- **The engaged patient:**
  - **Takes steps to be healthy**
  - **If unhealthy, understands medical condition and the therapies, asks questions, open to shared decision making**
  - **Prepares for expected events (childbirth, hospitalization, e.g. Coleman approach)**
  - **Understands the cost tradeoffs and the health tradeoffs**
- **Policies and plan design can support patient engagement**

Recent evaluation finds wellness programs can save



Baicker. Cutler. and Song. "Workplace Wellness Programs Can Generate Savings." Health Affairs. February 2010.

Considerations

- **Not everyone is capable of the same degree of engagement**
- **People will make different choices about therapies based on preferences, other health conditions**
- **Need to learn how to motivate people but avoid punishing the sick**
- **We will never "regulate efficiency into the system." Plan and payment strategies have to get the patient and provider interested**

How do we foster engagement?

Direct

- **Value based benefit design, reference pricing based on evidence of effectiveness**
- **Good wellness programs (include incentives)**
- **Decision aids based on evidence**
- **Changes to provider incentives that reward providers who engage patients**

Complementary strategies

- **Public policies that reverse the price of healthy and unhealthy food**
- **Recess and physical education**

The Cadillac plan of the past

- **Covers everything generously, leading to high use of services**
- **Wide networks, including good and poor providers**
- **Behind the scene paying claims – largely invisible**

The Excellent plan of the future

- **Fosters patient engagement**
- **Fosters delivery system reforms through payment innovations**
- **Uses evidence in coverage**
- **Large employers have led the way, but a role for health plans for smaller employers**
- **Program standards and measures could reward excellent health plans through special designation, financial incentives**

DISCUSSION